PATIENT AUTHORIZATION

FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name_____ Date of Birth_____

Address_____ City_____State____ Zip_____

SSN_____ Previous Name_____

I request and authorize _____ to release health care information of the patient named above to:

Name_____

Address_____

City, State_____Zip_____

This request and authorization applies to:

- ☐ Current X-rays
- ☐ Health care information relating to the following treatment, condition, or dates of treatment:

  _____

  _____

  _____
- ☐ All health care information
- ☐ Other:

This information will be disclosed for the following purposes:_____

_____.

_____

Signature of patient or authorized representative Date signed

_____